E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE SYRACUSE**
Tel: 888-843-2040
Fax: **888-842-3977**

☐ **NOBLE MISSISSIPPI**
Tel: 866-420-4041
Fax: **601-420-4040**

Multiple Sclerosis and Neurology

Delivery Need By: ___________ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other ____________

PATIENT INFORMATION

Patient Name: ______________________________ ☐ Male
Address: __________________________________ ☐ Female
City: __________________ State: _________ Zip: __________
Phone Number: ______________________________________
Email Address: ______________________________________
Last Four of Social: ________________ DOB: __________

PRESCRIBER INFORMATION

Prescriber's Name: ______________________________________
Office Contact Name: ____________________________________
Address: ____
City: ____________________ State: _________ Zip: __________
Phone Number: ______________ Fax: ______________________
DEA/NPA #: ____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ____
ICD-10 Code: ____
Height: ________ ft _______ inches Weight: ______ lbs
Allergies: ____

Has the patient been treated previously for this condition?
☐ Yes ☐ No
Medications Failed: _____________________________________
Medications On: ____
Other Notes: ____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Aubagio®	☐ 7mg tablet ☐ 14 mg tablet	☐ Take one tablet by mouth once a day ☐ Other	☐ 28 day supply ☐ Other	
Avonex®	☐ 30mcg Vial ☐ 30mcg SYR ☐ 30 mcg PEN	☐ Inject 30 mcg IM once a week ☐ Other	☐ 30 day supply ☐ Other	
Betaseron®	☐ 0.3 mg vial	☐ Inject .25 mg (1ml) SC every other day ☐ Other	☐ 28 day supply	
Botox®	☐ 100U ☐ 200U	☐ Inject _____ units as directed ☐ Other	☐ ______ # of vials	
Copaxone®	☐ 20mg/ml ☐ 40 mg/ml	☐ Inject 20 mg SC daily ☐ Inject 40 mg SC three times a week ☐ Other	☐ ____ day Supply ☐ Other	
dalfampridine	☐ 10mg extended-release tablet	☐ Take one tablet by mouth twice daily every 12 hours ☐ Other	☐ 30 day supply ☐ Other	
Elaprase	☐ 6mg/3ml	☐ Specified:	☐	
Gilenya®	☐ 0.5mg tablet	☐ Take one capsule by mouth once a day ☐ Other	☐ 30 day supply ☐ Other	
glatiramer acetate injection	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times per week and at least 48 hours apart ☐ Other	☐ _____ pre-filled syringes ☐ Other	
Glatopa®	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times per week and at least 48 hours apart ☐ Other	☐ _____ pre-Filled syringes	

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: ______________________________________ Date: ____________________

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Patient Name: ________________________ DOB: ________ Prescriber's Name: ______________________________________

PRESCRIPTION INFORMATION					
Medication:	Dosage/Strength:	Directions:		Quantity:	Refills:
Mayzent	☐ .25mg tablet ☐ 2 mg tablet	☐ Take ____ mg by mouth daily ☐ Other		☐ _____ day supply ☐ Other	
Rebif®	☐ 22mcg prefilled syringe ☐ 44 mcg prefilled syringe	☐ Inject ____ mcg SC three times a week ☐ Other			
Rebif® Rebidose	☐ 44mcg/0.5ml prefilled syringe	☐ Inject 44mcg SC three times a week ☐ Other			
Rebif® Rebidose Titration	☐ 8.8mcg/0.2ml – 22mcg/0.5ml	☐ Titration Schedule: Weeks 1-2: 4.4mcg (0.1ml) SC three times a week Weeks 3-4: 11mcg (0.25ml) SC three times a week Week 5+: 22mcg (.5ml) SC three times a week	☐ Titration Schedule: Week 1-2: 8.8mcg (0.1ml) SC three times a week Week 3-4: 22mcg (0.25ml) SC three times a week Week 5+: 44mcg (.5ml) SC three times a week	☐ 30 day supply ☐ Other	
		☐ Other			
Rebif® Syringe Titration	☐ 8.8mcg/0.2ml – 22mcg/0.5ml	☐ Titration Schedule: Weeks 1-2: 4.4mcg (0.1ml) SC three times a week Weeks 3-4: 11mcg (0.25ml) SC three times a week Week 5+: 22mcg (.5ml) SC three times a week	☐ Titration Schedule: Week 1-2: 8.8mcg (0.1ml) SC three times a week Week 3-4: 22mcg (0.25ml) SC three times a week Week 5+: 44mcg (.5ml) SC three times a week		
		☐ Other			
Other					
☐ Patient is interested in patient support programs		☐ Ancillary supplies provided for administration			

Physician Signature: ____ Date: ______________________________

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